The CHILD Project: ROAD TO RESLIENCE

R2R Program Summary

July 1, 2019 – June 30, 2021

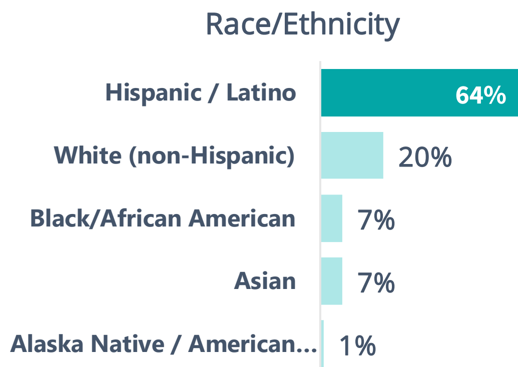
Program goals:

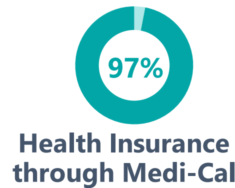
1. Improved maternal health and healthy infant/child development
2. Reduced risk of negative effects of substance use on children and their families
3. Prevention of child abuse and neglect
4. Prevention or reduction of behavioral, emotional, and developmental concerns in children
5. Improved early learning and school readiness

Yolo County pregnant mothers or parents with a child under one year old are eligible for R2R.

HOW MUCH DID WE DO?

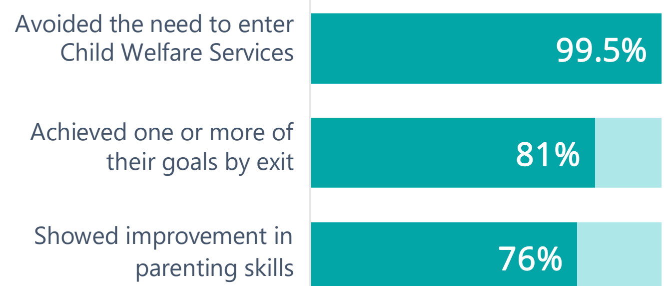
WHOM DO WE SERVE?





HOW WELL DID WE DO IT?

IS ANYONE BETTER OFF?



HOW DOES R2R IMPROVE CHILDREN'S HEALTH?

88%

Received medical postnatal visits

Postnatal care is key to **identifying depression** and **life-threatening complications**

88%

Up-to-date on well-child visits

28% higher than the overall clinic rate for the 6 recommended well child visits in the first 15 months of life

89%

Up-to-date on Immunizations

39% higher than the overall clinic rate in 2020

HOW DOES R2R IMPROVE MATERNAL HEALTH?

89%

Enrolled mothers considered moderate or high risk

96%

Reduced or continued non-use of alcohol, drugs, and tobacco

87%

Of participants* with initial depression risk score decreased follow-up score

**Behavioral Health Services clients*

*"My home visitor has done a great job helping me expand what I want to talk about and **helping me expand my thinking.**"* – R2R Client

HOW DOES R2R TRANSFORM SYSTEMS?

100%

of children in R2R are referred to Help Me Grow and receive developmental screenings

"It has not been easy for [my client] to ask for help, and the way you respond kindly, openly and quickly has been enormous in her progress toward doing this in other areas of her life."

-R2R Healthcare Provider Partner

R2R employs Team-Based Care and integrated data sharing.

- **Ensuring continuity of care** and integrating medical and social services by co-locating R2R Navigators in perinatal clinics with access to Electronic Health Records
- **Data sharing MOUs** with four community partners ensure secure, coordinated services
- **Increased developmental/behavioral health screenings and services** with timely follow-up
- **Increased capacity** of home visiting services and **connection** to community resources
- **Increased collaboration and teamwork** toward a common goal
- **Training and development** to deliver better family-centered services

*Note: *Communicare perinatal patients and outside referrals.*
Percentages exclude records with no information available. Outcomes data is based on FY 2020-2021.